National Diabetes Quality Improvement Alliance
Performance Measurement Set for Adult Diabetes

Approved February 2003
Released May 2003

Agency for Healthcare Research and Quality
American Academy of Family Physicians
American Association of Clinical Endocrinologists
American College of Physicians
American Diabetes Association
American Medical Association
Centers for Disease Control and Prevention
Centers for Medicare and Medicaid Services
Joint Commission on Accreditation of Healthcare Organizations
National Committee for Quality Assurance
National Institute of Diabetes and Digestive and Kidney Diseases
The Endocrine Society
U.S. Department of Veterans Affairs

A1c Management

Importance for Patient Care	Clinical Recommendations*		Performance Measures (per year)		Rationale
	Description of Recommendations	Treatment Goals	For Purposes of Quality Improvement	For Purposes of Public Reporting	
Intensive therapy of glycosylated hemoglobin (A1c) reduces the risk of microvascular complications.[1,2,3]	American Association of Clinical Endocrinologists/American College of Endocrinology (AACE/ACE): Recommend that a glycosylated hemoglobin be performed during an initial assessment and during follow-up assessments, which should occur at no longer than three-month intervals.[4] American Diabetes Association (ADA): Recommends obtaining a glycosylated hemoglobin during an initial assessment and then routinely as part of continuing care. In the absence of well-controlled studies that suggest a definite testing protocol, expert opinion recommends glycosylated hemoglobin be obtained at least twice a year in patients who are meeting treatment goals and who have stable glycemic control and more frequently (quarterly assessment) in patients whose therapy was changed or who are not meeting glycemic goals.[5]	AACE/ACE: Recommend that A1c be universally adopted as the primary method of assessment of glycemic control. On the basis of data from multiple interventional trials, the target for attainment of glycemic control should be A1c values ≤6.5%.[4] ADA: Because different assays can give varying glycated hemoglobin values, the ADA recommends that laboratories only use assay methods that are certified as traceable to the Diabetes Control and Complications Trial A1c reference method. The ADA's goal for glycemic control is A1c <7%.[5]	**Per patient** Number of A1c tests received** Trend of A1c values **Across all patients** Percentage of patients receiving one or more A1c test(s) Distribution of number of tests done (0, 1, 2, 3 or more) Distribution of most recent A1c value by range: <6.0% 6.0-6.9% 7.0-7.9% 8.0-8.9% 9.0-9.9% ≥10.0% undocumented	Percentage of patients with one or more A1c test(s) Percentage of patients with most recent A1c level >9.0% (poor control)	Please note the differences between the clinical recommendations/ treatment goals and the performance measures. Measures are *not* clinical recommendations; measures are derived from clinical recommendations and must account for differences in individual patient conditions and preferences, feasibility of data collection, actionability by user, etc.[6] The quality improvement measures are intended primarily to facilitate provider tracking of *individual* patient management with clinical recommendations/treatment goals. Data collection may be through abstracting paper medical records, completing paper flowsheets prospectively, or utilizing electronic data systems. The public reporting measures are *population* level measures; the data must be available from all users utilizing existing standardized data sources such as claims data or medical record abstraction. **2003 Update** The performance measure for purposes of public reporting was changed from poor control defined as >9.5% to poor control defined as >9.0%. Clearly, the clinical recommendations and treatment goals for persons with diabetes define the target A1c level as =<6.5% or <7.0%. Please note, however, that the Alliance public reporting measure focuses on "poor control" as opposed to "target, or good control." The Alliance public reporting measure for poor control is >9.0% for several reasons: 1) Many valid clinical reasons may exist why an individual patient does not achieve an A1c level =<6.5% or <7.0%. Therefore, it is not appropriate to hold a large group (eg, a health plan) accountable for a population reaching an A1c level =<6.5% or <7.0%. Most would agree, however, that an A1c level >9.0% is poor control for all patient types. The QI measures enable a provider to track an individual patient's progress toward the target goal. 2) For population-based measurement, it is desirable to have a distribution of results so that populations can be distinguished. Based on NCQA HEDIS data, 36.9% of health plans reporting data in 2001 had population level A1c values >9.5%.[7] Therefore, the median value is <9.5%. 3) Because of the National Glycohemoglobin Standardization Program, the vast majority of laboratories now use standardized assays. Because of the decreased variability in laboratory procedures, the overall reported levels for A1c have decreased.

* Please note that the recommendations are listed alphabetically by author; no preference or order of importance is implied.

** This measure is not intended to imply an optimal number of tests or visits. Treatment must be based on individual patient needs and professional judgement.

Lipid Management

Importance for Patient Care	Clinical Recommendations*			Performance Measures (per year)		Rationale
	Description of Recommendations	Treatment Goals		For Purposes of Quality Improvement	For Purposes of Public Reporting	
Persons with diabetes are at increased risk for coronary heart disease (CHD). Lowering serum cholesterol levels can reduce the risk for CHD events.[8]	AACE/ACE: Recommend that a fasting lipid profile be obtained during an initial assessment, each follow-up assessment, and annually as part of the cardiac-cerebrovascular-peripheral vascular module.[4,9] ADA: Recommends that a fasting lipid profile be obtained as part of an initial assessment. Adult patients with diabetes should be tested annually for lipid disorders with fasting serum cholesterol, triglycerides, HDL cholesterol, and calculated LDL cholesterol measurements. If values fall in lower-risk levels, assessments may be repeated every two years.[5]			**Per patient** Trend of values for each test	Percentage of patients with at least one LDL-C test Percentage of patients with most recent LDL-C <130	Please note the differences between the clinical recommendations/treatment goals and the performance measures. Measures are *not* clinical recommendations; measures are derived from clinical recommendations and must account for differences in individual patient conditions and preferences, feasibility of data collection, actionability by user, etc.[6] The quality improvement measures are intended primarily to facilitate provider tracking of *individual* patient management with clinical recommendations/treatment goals. Data collection may be through abstracting paper medical records, completing paper flowsheets prospectively, or utilizing electronic data systems. The public reporting measures are *population* level measures; the data must be available from all users utilizing existing standardized data sources such as claims data or medical record abstraction. **2003 Update** The performance measures remain unchanged from 2002. Clearly, the clinical recommendations and treatment goals for persons with diabetes define as the target LDL-C level < 100. The Alliance public reporting measure remains at <130 for two reasons: 1) Many valid clinical reasons may exist why an individual patient does not achieve an LDL-C level <100. Therefore, it is not appropriate to hold a large group (eg, a health plan) accountable for a population reaching an LDL-C <100. The QI measures enable a provider to track an individual patient's progress toward the target goals. 2) For population-based measurement, it is desirable to have a distribution of results so that populations can be distinguished. Based on NCQA HEDIS® 2001 data, at least 50% of health plans currently do not meet a population level of LDL-C <130.[7] Therefore, room for improvement remains at this level.
				Across all patients Percentage of patients receiving at least one lipid profile (or ALL component tests)		
		Total Cholesterol	AACE/ACE[9]: Acceptable <200 Ideal <170	Distribution of most recent test values by range: ≥240 200-239 <200 undocumented		
		LDL Cholesterol (LDL-C)	AACE/ACE[9]: Acceptable <130 Ideal <100 ADA[5,8]: Low (Target) <100 NCEP[10]: Normal/Optimal <100	≥160 130-159 100-129 <100 undocumented If Non-HDL cholesterol is reported, record the test values in the following ranges: ≥190 160-189 130-159 <130 undocumented		
		HDL Cholesterol	AACE/ACE[9]: Acceptable >35 Ideal >45 ADA[5,8]: Target (men) >45 Target (women) >55	<40 40-49 50-59 ≥60 undocumented		
		Triglycerides	AACE/ACE[9]: Acceptable <200 Ideal <150 ADA[5,8]: Target <150	≥400 200-399 <200 150-199 <150 undocumented		

Note: Data are given in milligrams per deciliter

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Urine Protein Screening

Importance for Patient Care	Clinical Recommendations*	Performance Measures (per year)		Rationale
		For Purposes of Quality Improvement	For Purposes of Public Reporting	
Diabetes is the leading cause of end-stage renal disease (ESRD).[11] In the United States, diabetic nephropathy accounts for about one-third of all cases of ESRD. The earliest clinical evidence of nephropathy is the appearance of low, but abnormal levels of albumin (protein) in the urine, referred to as microalbuminuria. Early detection and treatment may prevent or slow the progression of diabetic nephropathy.[12]	AACE/ACE: Recommends that the initial assessment should include a urinalysis, test for microalbuminuria and creatinine clearance. The renal complication module should be performed annually and includes a test for microalbuminuria and creatinine clearance.[4] ADA: Recommends that a routine urinalysis be performed at diagnosis in patients with type 2 diabetes. If the urinalysis is positive for protein, a quantitative measure is frequently helpful in the development of a treatment plan. If the urinalysis is negative for protein, a test for the presence of microalbumin is necessary.[12] Microalbuminuria rarely occurs with short duration of type 1 diabetes; therefore, screening in individuals with type 1 diabetes should begin after 5 years' disease duration. However, some evidence suggests that the prepubertal duration of diabetes may be important in the development of microvascular complications; therefore, clinical judgment should be exercised when individualizing these recommendations. Because of the difficulty in precise dating of the onset of type 2 diabetes, such screening should begin at the time of diagnosis. After the initial screening and in the absence of previously demonstrated microalbuminuria, a test for the presence of microalbumin should be performed annually.[12] National Kidney Foundation (NKF): Individuals at increased risk, but found not to have chronic kidney disease, should be advised to follow a program of risk factor reduction, if appropriate, and undergo repeat periodic evaluation.[13]	**Per patient** Any test for microalbuminuria received If no urinalysis OR urinalysis with negative or trace urine protein, a test for microalbumin was received **Across all patients** Percentage of patients who received any test for microalbuminuria Percentage of patients with no urinalysis OR urinalysis with negative or trace urine protein, who received a test for microalbumin	Percentage of patients with at least one test for microalbumin during the measurement year; or who had evidence of medical attention for existing nephropathy (diagnosis of nephropathy or documentation of microalbuminuria or albuminuria)	Please note the differences between the clinical recommendations/treatment goals and the performance measures. Measures are *not* clinical recommendations; measures are derived from clinical recommendations and must account for differences in individual patient conditions and preferences, feasibility of data collection, actionability by user, etc.[6] The quality improvement measures are intended primarily to facilitate provider tracking of *individual* patient management with clinical recommendations/treatment goals. Data collection may be through abstracting paper medical records, completing paper flowsheets prospectively, or utilizing electronic data systems. The public reporting measures are *population* level measures; the data must be available from all users utilizing existing standardized data sources such as claims data or medical record abstraction. **2003 Update** The performance measure for purposes for public reporting was changed for 2003. The 2002 public reporting measure allowed testing for microalbumin every two years if two out of three criteria were met (patient not on insulin, A1c <8.0%, no evidence of albumin in prior year). This measure now requires that testing for microalbumin be completed each year. Because the clinical recommendations support annual testing for microalbuminuria, the every two-year option was omitted. Patients who have documented evidence of a diagnosis of nephropathy or documentation of microalbuminuria or albuminuria are excluded from this measure.

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Eye Examination

Importance for Patient Care	Clinical Recommendations*	Performance Measures (per year)		Rationale
		For Purposes of Quality Improvement	For Purposes of Public Reporting	
Retinopathy poses a serious threat to vision. The prevalence of retinopathy is strongly related to the duration of diabetes. Treatment modalities exist that can prevent or delay diabetic retinopathy.[14]	AACE/ACE, ADA, and American Academy of Ophthalmology (AAO): Recommend that a dilated eye examination be performed on patients with diabetes during an initial assessment and at least annually thereafter.[4,14,15] AACE/ACE: Recommend that the annual eye examination be performed as part of a retinal module. The module includes test of visual acuity (Snellen chart); funduscopic examination and intraocular pressure (IOP) test. The AACE/ACE recommend that diabetic patients should be under the care of an ophthalmologist experienced in the management of diabetic retinopathy. AACE/ACE further believes that a dilated eye exam should only be done by an MD/DO.[4] ADA: The recommendation includes an annual comprehensive dilated eye and visual examination by an ophthalmologist or optometrist who is knowledgeable and experienced in the management of diabetic retinopathy for: all patients aged 10 years and older who have had diabetes for three to five years; all patients diagnosed after age 30; and any patient with visual symptoms and/or abnormalities. However, some evidence suggests that the prepubertal duration of diabetes may be important in the development of microvascular complications; therefore, clinical judgment should be exercised when individualizing these recommendations.[14] In addition, poorly controlled patients or those undergoing the initiation and stabilization of treatment may need to be seen by a physician on a quarterly basis. In such cases, the quarterly visit should include a funduscopy and appropriate referral if retinopathy is detected.[14] AAO: Recommends that diabetic patients should be under the care of an ophthalmologist experienced in the management of diabetic retinopathy. Ophthalmologists with specialized knowledge and experience in managing the disease are best able to detect and treat serious disease.[15] American Optometric Association: Recommends eye examinations to determine level of diabetic retinopathy as follows (individual situations and level of eye disease may suggest more frequent eye examinations): Patients aged 29 years or younger (generally type 1 diabetes): within 3-5 years after diagnosis of diabetes once a person is age 10 years or older, and annually thereafter Patients aged 30 years or older (generally type 2 diabetes): at the time of diagnosis, and annually thereafter Pregnancy in pre-existing diabetes: prior to conception and during the first trimester, with follow-up evaluation during pregnancy based on findings of the first trimester examination and 6-8 weeks *post partum*.[16]	**Per patient** Dilated retinal eye exam performed by an ophthalmologist or optometrist Funduscopic photo with interpretation performed by an ophthalmologist or optometrist **Across all patients** Percentage of patients receiving a dilated retinal eye exam by an ophthalmologist or optometrist Percentage of patients receiving funduscopic photo with interpretation by an ophthalmologist or optometrist	Percentage of patients who received a dilated eye exam or evaluation of retinal photographs by an ophthalmologist or optometrist during the reporting year, or during the prior year, if patient is at low risk* for retinopathy A patient is considered low risk if all three of the following criteria are met: - the patient is not taking insulin - has an A1c <8.0% - has no evidence of retinopathy in the prior year	Please note the differences between the clinical recommendations/treatment goals and the performance measures. Measures are *not* clinical recommendations; measures are derived from clinical recommendations and must account for differences in individual patient conditions and preferences, feasibility of data collection, actionability by user, etc.[6] The quality improvement measures are intended primarily to facilitate provider tracking of *individual* patient management with clinical recommendations/treatment goals. Data collection may be through abstracting paper medical records, completing paper flowsheets prospectively, or utilizing electronic data systems. The public reporting measures are *population* level measures; the data must be available from all users utilizing existing standardized data sources such as claims data or medical record abstraction. **2003 Update** The quality improvement measures were changed for 2003 for the following reason: 1) Because the recommendations call for the exam to be completed by a provider certified in retinal eye exams, this clause requiring that the exam be performed by an ophthalmologist or optometrist was added to each of the quality improvement measures. The public reporting measure was changed and now requires all three criteria be met in order to classify a patient as low risk. The previous measure, which required that only two out of the three criteria were needed to classify patients as low risk, was considered inadequate. For instance, if the patient was not taking insulin and had no evidence of retinopathy in the prior year but had an A1c >8.0%, he/she could still be considered at risk for retinopathy. Some investigators who examined the risk associated with diabetic retinopathy[17,18,19,20] suggest that it is appropriate to perform biannual eye exams for those patients who can be classified as low risk.

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Foot Examination

<table>
<tr><th rowspan="2">Importance for Patient Care</th><th rowspan="2">Clinical Recommendations*</th><th colspan="2">Performance Measures (per year)</th><th rowspan="2">Rationale</th></tr>
<tr><th>For Purposes of Quality Improvement</th><th>For Purposes of Public Reporting</th></tr>
<tr><td rowspan="3">Persons with diabetes are at increased risk for foot ulcers and amputations. Annual, thorough foot examinations and management of risk factors can prevent or delay adverse outcomes.[21]</td><td rowspan="3">AACE/ACE and ADA:
Recommend that a foot examination (visual inspection, sensory exam, and pulse exam) be performed during an initial assessment.[4,21]

AACE/ACE:
Recommends that a foot examination be a part of every follow-up assessment visit, which should occur quarterly.

ADA:
Recommends that all individuals with diabetes should receive an annual foot examination to identify high-risk foot conditions. This examination should include assessment of protective sensation, foot structure and biomechanics, vascular status, and skin integrity.

The ADA recommends that people with one or more high-risk foot conditions should be evaluated more frequently for the development of additional risk factors. People with neuropathy should have a visual inspection of their feet at every contact with a health care professional.[21]</td><td>Per patient

At least one complete foot exam received (visual inspection, sensory exam with monofilament, and pulse exam)</td><td rowspan="2">Percentage of eligible patients receiving at least one foot exam, defined in any manner</td><td rowspan="3">Please note the differences between the clinical recommendations/treatment goals and the performance measures. Measures are not clinical recommendations; measures are derived from clinical recommendations and must account for differences in individual patient conditions and preferences, feasibility of data collection, actionability by user, etc.[6]

The quality improvement measures are intended primarily to facilitate provider tracking of individual patient management with clinical recommendations/treatment goals. Data collection may be through abstracting paper medical records, completing paper flowsheets prospectively, or utilizing electronic data systems.

The public reporting measures are population level measures; the data must be available from all users utilizing existing standardized data sources such as claims data or medical record abstraction.

2003 Update

The performance measures remain unchanged from 2002.

In 2003, the Alliance will explore the reliability, validity, and feasibility of reporting one, or more than one, of the three components used to outline a complete foot exam in the quality improvement measures, as part of a future public reporting measure.</td></tr>
<tr><td>Across all patients

Percentage of eligible patients receiving at least one complete foot exam (visual inspection, sensory exam with monofilament, and pulse exam)</td></tr>
<tr><td colspan="2">Exclusion Criteria: Patients with bilateral foot amputation</td></tr>
</table>

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Influenza Immunization

<table>
<tr><th rowspan="2">Importance for Patient Care</th><th rowspan="2">Clinical Recommendations*</th><th colspan="2">Performance Measures (per year)</th><th rowspan="2">Rationale</th></tr>
<tr><th>For Purposes of Quality Improvement</th><th>For Purposes of Public Reporting</th></tr>
<tr><td rowspan="3">Patients with diabetes are considered to be at increased risk for complications, hospitalization, and death from influenza and pneumococcal disease.[22]</td><td rowspan="3"><u>Advisory Committee on Immunization Practices:</u>
Immunization for influenza is strongly recommended for any person 6 months of age or older who, because of age or underlying medical condition, is at increased risk for complications of influenza.[23]

<u>ADA:</u>
Recommends an influenza vaccine for patients with diabetes, aged ≥6 months, beginning each September.[22]</td><td>Per patient

Immunization status</td><td rowspan="2">None</td><td rowspan="3">Please note the differences between the clinical recommendations/treatment goals and the performance measures. Measures are not clinical recommendations; measures are derived from clinical recommendations and must account for differences in individual patient conditions and preferences, feasibility of data collection, actionability by user, etc.[6]

The quality improvement measures are intended primarily to facilitate provider tracking of individual patient management with clinical recommendations/treatment goals. Data collection may be through abstracting paper medical records, completing paper flowsheets prospectively, or utilizing electronic data systems.

2003 Update

The performance measures remain unchanged form 2002.

The measure remains inappropriate for public reporting purposes for two reasons:
1) The data needed for this measure are often not readily available from claims data.
2) Abstraction from the medical record cannot be considered reliable for this aspect of care due to the fact that often patients do not receive their influenza immunization from their provider but from other community sources.</td></tr>
<tr><td>Across all patients**

Percentage of patients who received an influenza immunization during the recommended calendar period

Percentage of eligible patients who received an immunization or refused immunization during the calendar period</td></tr>
<tr><td colspan="2">Exclusion criteria: Patients allergic to eggs</td></tr>
</table>

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** It is recommended that data be reported two ways in recognition of patient preferences.

Blood Pressure Management

Importance for Patient Care	Clinical Recommendations*		Performance Measures (per year)		Rationale
	Description of Recommendations	Treatment Goals	For Purposes of Quality Improvement	For Purposes of Public Reporting	
Intensive control of blood pressure in patients with diabetes reduces diabetes complications, diabetes-related deaths, strokes, heart failure, and microvascular complications.[24]	AACE/ACE: Recommends that a blood pressure determination during the initial evaluation, including orthostatic evaluation, be included in the initial and every interim physical examination.[4] ADA: Recommends a blood pressure determination during the initial evaluation (with orthostatic measurements when indicated) and comparison to age-related norms. The routine follow-up examinations should include blood pressure measurement.[5] JNC VI: Recommends that to detect evidence of autonomic dysfunction and orthostatic hypertension, blood pressure should be measured in the supine, sitting, and standing positions in all patients with diabetes mellitus; automated ambulatory blood pressure monitoring may be especially helpful. NKF: Recommends that all individuals should be evaluated during health encounters to determine whether they are at increased of having or of developing chronic kidney disease. This evaluation of risk factors should include blood pressure measurement.[13]	ADA Primary goal for adults:[5] <130/80 mm Hg JNC VI[25] Antihypertensive drug therapy should be initiated along with lifestyle modifications, especially weight loss, to reduce arterial blood pressure to below 130/85 mm Hg. For patients with renal insufficiency or proteinuria, further reduction of blood pressure to 120/75 mm Hg is recommended.	Per patient Most recent systolic and diastolic blood pressure reading Across all patients Distribution of most recent blood pressure values by range: Systolic (mm Hg): <120 120-129 130-139 140-149 150-159 160-169 170-179 ≥180 undocumented Diastolic (mm Hg): <75 75-79 80-89 90-99 100-109 ≥110 undocumented	Percentage of patients with most recent blood pressure <140/90 mm Hg	Please note the differences between the clinical recommendations/treatment goals and the performance measures. Measures are *not* clinical recommendations; measures are derived from clinical recommendations and must account for differences in individual patient conditions and preferences, feasibility of data collection, actionability by user, etc.[6] The quality improvement measures are intended primarily to facilitate provider tracking of *individual* patient management with clinical recommendations/treatment goals. Data collection may be through abstracting paper medical records, completing paper flowsheets prospectively, or utilizing electronic data systems. The public reporting measures are *population* level measures; the data must be available from all users utilizing existing standardized data sources such as claims data or medical record abstraction. **2003 Update** The reported values for the quality improvement measures have been changed for 2003 to allow for greater specificity in reporting. Clearly, the clinical recommendations and treatment goals for persons with diabetes define as the target blood pressure <130/85 mm Hg. The Alliance public reporting measure remains at <140/90 for two reasons: 1) Many valid reasons may exist why an individual patient does not achieve a target blood pressure <130/85 mm Hg. Therefore, it is not appropriate to hold a large group (eg, a health plan) accountable for a population reaching a blood pressure <130/85 mm Hg. 2) For population-based measurement, it is desirable to have a distribution of results so that populations can be distinguished. Based on NCQA HEDIS® 2001 data for the treatment of hypertension, at least 55% of commercial health plans currently do not meet a population level of <140/90.[7] Therefore, room for improvement remains at this level.

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Aspirin Use

<table>
<tr><th rowspan="2">Importance for Patient Care</th><th rowspan="2">Clinical Recommendations*</th><th colspan="2">Performance Measures (per year)</th><th rowspan="2">Rationale</th></tr>
<tr><th>For Purposes of Quality Improvement</th><th>For Purposes of Public Reporting</th></tr>
<tr>
<td rowspan="3">Daily low-dose aspirin therapy is important for both primary and secondary prevention of cerebral and cardiac events.[4]

Aspirin has been used as a primary and secondary therapy to prevent cardiovascular events in diabetic individuals.[5]</td>
<td rowspan="3">AACE/ACE:
Recommends that optimal care of the diabetic patient include the use of antiplatelet therapy for prevention of vascular events. Prevention of vascular events by the antiplatelet effect of daily low-does aspirin (as low as 30mg/day) has been well established. Daily low-dose aspiring therapy is important for both primary and secondary prevention of cerebral and cardiac events.[4]

ADA:
Recommends aspirin therapy as a secondary prevention strategy in diabetic men and women who have evidence of large vessel disease. This includes diabetic men and women with a history of MI, vascular bypass procedure, stroke or transient ischemic attack, peripheral vascular disease, claudication, and/or angina.[26]

Use aspirin therapy (75-325mg/day) in all adult patients with diabetes and macrovascular disease.[5,26]

Do not use aspirin in patients <21 years of age because of the increased risk of Reye's syndrome.[26]

Recommends that people with aspirin allergy, bleeding tendency, anticoagulant therapy, recent gastrointestinal bleeding, and clinically active hepatic disease are not candidates for aspirin therapy.[26]

Recommends aspirin therapy as a primary prevention in high-risk men and women with type 1 or type 2 diabetes. This includes:
- Family history of coronary heart disease
- Cigarette smoking
- Hypertension
- Obesity (>120% desirable weight); BMI >27.3kg/m2 in women, >27.8kg/m2 in men
- Albuminuria (micro or macro)
- Lipids: cholesterol >200mg.dl, LDL ≥100m.dl, HDL <45mg/dl in men and <55 in women
- Age >30years</td>
<td>Per patient

Patient receiving aspirin therapy (dose ≥ 75 mg)</td>
<td rowspan="2">None</td>
<td rowspan="3">Please note the differences between the clinical recommendations/treatment goals and the performance measures. Measures are not clinical recommendations; measures are derived from clinical recommendations and must account for differences in individual patient conditions and preferences, feasibility of data collection, actionability by user, etc.[6]

The quality improvement measures are intended primarily to facilitate provider tracking of individual patient management with clinical recommendations/treatment goals. Data collection may be through abstracting paper medical records, completing paper flowsheets prospectively, or utilizing electronic data systems.

The public reporting measures are population level measures; the data must be available from all users utilizing existing standardized data sources such as claims data or medical record abstraction.

2003 Update

New Quality Improvement measure for 2003.

This measure remains appropriate only for quality improvement purposes for two reasons:
1) The data needed for this measure are often not readily available from claims data.
2) Abstraction from the medical record cannot be considered reliable for this aspect of care in part because this drug is available over the counter and often is not recorded.</td>
</tr>
<tr>
<td>Across all patients

Percentage of patients receiving aspirin therapy (dose ≥ 75 mg)</td>
</tr>
<tr>
<td colspan="2">Exclusion criteria: patients <40 years old, aspirin contraindication/allergy</td>
</tr>
</table>

* Please note that the recommendations are listed alphabetically by author; no preference or order of importance is implied.

Smoking Cessation

Importance for Patient Care	Clinical Recommendations*	Performance Measures (per year)		Rationale
		For Purposes of Quality Improvement	For Purposes of Public Reporting	
	AACE/ACE: Recommends assessment of smoking history during the initial visit. Optimal care of the patient with diabetes must include cessation of smoking.[4] ADA: Recommends routine and thorough assessment of tobacco use. Health care providers should advise all individuals with diabetes not to smoke.[5] For people who smoke, the ADA recommends implementation of smoking cessation guidelines incorporated into the routine practice of diabetes care.[5]	**Per patient** Patient assessed for smoking status Patient identified as a smoker was recommended or offered counseling or pharmacologic therapy **Across all patients** Percentage of patients who are smokers Percentage of patients assessed for smoking status Percentage of smokers who were recommended or offered an intervention for smoking cessation (ie, counseling or pharmacologic therapy)	Percentage of patients whose smoking status was ascertained and documented annually	Please note the differences between the clinical recommendations/treatment goals and the performance measures. Measures are *not* clinical recommendations; measures are derived from clinical recommendations and must account for differences in individual patient conditions and preferences, feasibility of data collection, actionability by user, etc.[6] The quality improvement measures are intended primarily to facilitate provider tracking of *individual* patient management with clinical recommendations/treatment goals. Data collection may be through abstracting paper medical records, completing paper flowsheets prospectively, or utilizing electronic data systems. The public reporting measures are *population* level measures; the data must be available from all users utilizing existing standardized data sources such as claims data or medical record abstraction. **2003 Update** New Quality Improvement and Public Reporting measures for 2003.

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